TRANSFER OF RESIDENTS

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Transfer of Residents Between Facilities

Infection and/or colonization of residents with microorganisms, including the multiply resistant category, can be managed in the long term care setting utilizing body substance precautions.[1] Open and honest communication of resident clinical information between the transferring facilities is essential to maintain optimum infection control for residents and employees of both facilities.

Admission to Long Term Care Facility

1. Prior to the nursing home admission, the facility should request clinical information from the transferring facility regarding current culture reports of the resident's body sites that may be infected or colonized with pathogenic organisms, especially multiply resistant organisms. This action will enable the nursing staff to determine the nursing care interventions necessary to meet the resident's needs.(See Figure 6.1-1 for an example of a transfer form.)

2. The facility should also request clinical information from the transferring facility to determine the resident's risk factors for colonization with multiply resistant organisms (i.e. long hospital stay, ICU stay).

3. The facility should review all pertinent clinical information on the transfer form accompanying the resident upon admission to the facility.

4. The facility may not deny admission to a resident based upon the diagnosis of MRSA or any other multiply resistant organism or infectious disease, unless the long term care facility is unequipped to provide appropriate care for the resident.[2]

Transfer to the Hospital or Another Long Term Care Facility

1. When transferring a long term care (LTC) resident to a hospital or another LTC facility, the facility coordinating the discharge should prepare a transfer form and send it with the resident. The transfer form should show pertinent clinical data including the resident's medical history, diagnoses, presenting signs and symptoms, status of infectious disease (particularly multiply resistant organisms), appropriate culture reports/data, and current antibiotic therapy. (See Figure 6.1-1.)

2. The discharging facility should notify the admitting hospital or LTC facility by phone if laboratory data pertinent to the resident's clinical care is received **after** the resident's discharge. Such important information would include:
    - any abnormal blood work;
    - any positive culture report;
    - information that the resident had been exposed to an infectious disease outbreak in the LTC prior to transfer.

Communication Between Facilities

There should be open communication between facilities permitting the exchange of information about the patient or resident. The LTC facility should notify the admitting facility when a multiply resistant organism or communicable disease is identified on a resident recently discharged from the facility. The LTC facility should expect and request the same information of the facility from which the resident was transferred. This communication and cooperative action will permit both facilities to track the patients/residents to identify potential communicable disease exposure. All information exchanged must be handled in a manner to maintain the resident's confidentiality of medical care and treatment. **Transfer agreements between facilities provide efficient mechanisms to formalize the appropriate content and methods for patient/resident information exchange.**

References

1. Strausbaugh LJ, Jacobson C, Sewell DL, Potter S, Ward TT. Methicillin-resistant *Staphylococcus aureus* in extended care facilities: experiences in a veterans affairs nursing home and a review of the literature. Infection Control and Hospital Epidemiology 1991;1:36-45.
2. Division of Aging, Missouri Department of Social Services. 13 CSR 15-14.042 Administration and Resident Care Requirements for New and Existing Intermediate Care and Skilled Nursing Facilities and 13 CSR 15-15.042 Administrative, Personnel and Resident Care Requirements for New and Existing Residential Care Facilities I and II. Code of State Regulations, September 30, 1998.

Figure 6.1-1

(Sample) Long Term Care
Patient Transfer Form

Patient's Last Name	First Name	MI	Sex ☐M ☐F	Health Insurance Claim Number

Patient's Address (Street Number, City, State, Zip Code)	Date of Birth	Religion

Date of This Transfer	Facility Name and Address Transferring to

Dates of Qualifying Stay FROM ____/____/____ THRU ____/____/____	Facility Name and Address Transferring from Qualifying and Other Prior Stay Information (Including Medical Record Numbers)

Date of Last Physical Examination	Policy or Medical Assistance No.

Insuring Organization or State Agency Name and Address	Advanced Directive Status:

ATTENDING PHYSICIAN INFORMATION

1. Name and Address of Physician at New Facility

2. Final Diagnosis(es), or Photocopy Attached ☐
   PRIMARY

   ALL OTHER CONDITIONS

3. Surgical Procedure(s) and Date(s) or, Check None ☐

4. Physician Orders on Transer: See Attached

Presenting Signs and Symptoms - Check All That Apply

___ rash	___ fever	___ resistant organism
___ cough:	___ weight loss	___ hospitalization >7 days
___ productive		___ antibiotic therapy

5. Estimated Medically Necessary Stay:
   _____Days _____Weeks or _____Months

6. Drug Sensitivities or, Check None ☐

7. Dietary Regimen:

8. Physician's Signature Date

NURSING EVALUATION

9. Speech	☐ Normal	☐ Impaired	☐ Unable to Speak	
10. Hearing	☐ Normal	☐ Impaired	☐ Deaf	
11. Sight	☐ Normal	☐ Impaired	☐ Blind	
12. Mental Status	☐ Always Alert	☐ Occasionally Confused	☐ Always Confused	
13. Feeding	☐ Independent	☐ Help With Feeding	☐ Cannot Feed Self	
14. Dressing	☐ Independent	☐ Help With Dressing	☐ Cannot Dress Self	
15. Elimination	☐ Independent	☐ Help to Bathroom	☐ Bedpan or Urinal Required	☐ Incontinent
16. Bathing	☐ Independent	☐ Bathing With Help	☐ Bed Bath With Help	☐ Bed Bath
17. Ambulatory Status	☐ Independent	☐ Walks With Assistance	☐ Help From Bed to Chair	☐ Bed Bound

18. Dressings and Bandages: or, Check None ☐

19. Appliances or Supports: or, Check None ☐

20. Infectious Disease or Check None ☐

Positive Cultures at this Time of Transfer or Check None ☐

Summary Attached ☐ Yes ☐ No

21. Signature Title Date

SOCI

22. Name and Address of Person to Contact:	Relationship to Patient Telephone Number	23. Summary Attached ☐ Yes ☐ No

24. Post Stay Plans:

25. Signature Date	Title